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Implementation of an Early Preventive Intervention Programme for Child Neglect: SafeCare

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Abstract

Background: Child neglect is the most prevalent type of child maltreatment. Research has shown that its sequelae can be more harmful than physical or sexual abuse, particularly at early ages, supporting the importance of preventive and early interventions. This paper presents the results of the first pilot implementation in Spain of SafeCare, a home visiting evidence-based programme for the prevention and treatment of child neglect in families with children aged 0-5 years old. **Method:** Between 2014 and 2017, 89 families were referred from Child Protection Services of Gipuzkoa and San Sebastian to SafeCare. Of these, 46 finished the programme. Parenting skills, depressive symptomatology, child abuse potential, parental stress, and child behavioural problems were measured at baseline and after treatment. Parental satisfaction with the programme was evaluated after treatment. **Results:** High levels of parental satisfaction, significant improvements in parenting skills, and significant decreases in child abuse potential, parental stress, and perception of child behavioural problems were found after treatment. **Conclusions:** Findings suggested that SafeCare can be useful for families with early signs of child neglect. The study also confirmed the feasibility of implementing such an evidence based programme in Child Protective Services in Spain. More studies with larger samples and experimental designs are necessary.

Keywords: Child neglect, prevention, early intervention, SafeCare programme.

Resumen

Implantación de un programa de intervención de prevención temprana para la negligencia infantil: SafeCare. **Antecedentes:** la negligencia es la tipología más frecuente de maltrato infantil. Sus secuelas pueden ser incluso más dañinas que el maltrato físico o el abuso sexual, particularmente a edades tempranas, apoyando la importancia de intervenciones preventivas y precoces. En este artículo se presentan resultados de la primera implantación piloto en España de SafeCare, un programa basado en la evidencia para la intervención con familias negligentes o en riesgo con niños 0-5 años. **Método:** entre 2014 y 2017, los Servicios de Protección Infantil de Gipúzkoa y San Sebastián derivaron 89 familias al programa. De ellas, 46 lo completaron. Antes y después del tratamiento se evaluaron competencias parentales, sintomatología depresiva, potencial de maltrato físico, estrés parental y percepción de problemas de conducta. **Resultados:** se observaron mejoras significativas en competencias parentales, potencial de maltrato físico, estrés parental y percepción de problemas de conducta, y una elevada satisfacción de los padres y madres participantes. **Conclusiones:** los resultados sugieren que SafeCare puede ser útil para familias con signos tempranos de negligencia. Se constató también la viabilidad de la implantación de un programa basado en la evidencia en Servicios de Protección Infantil en España. Sería necesario replicar estos hallazgos con muestras más amplias y diseños experimentales.

Palabras clave: negligencia infantil, prevención, intervención precoz, programa SafeCare.

Child maltreatment is a significant social and health problem at international level (Fang, Brown, Florence, & Mercy, 2012; Stoltenborgh, Bakermans-Kranenburg, Alink, & van Ijzendoorn, 2015). Child neglect is one of the main types of child maltreatment. It has been defined as the chronic or repeated lack of attention to the basic physical, safety, educational or psychological needs of the child, and includes absence of sufficient attention, responsiveness and protection that are appropriate for the child's age and needs, failure to provide minimal care, and lack of supervision that cause risk of severe damage (Dubowitz, Papas, Black, & Starr, 2002).

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Neglect is the most prevalent form of child maltreatment. It represents 40-75% of substantiated cases in the different age groups in Child Protection Services from developed countries (Gilbert et al., 2009; Radford et al., 2011; Stoltenborgh, Bakermans-Kranenburg, & van Ijzendoorn, 2013). High prevalence rates have been also found in studies with self-report measures in the general population (Moody, Cannings-John, Hood, Kemp, & Robling, 2018). A recent meta-analysis estimated that more than 15% of the children could be victims of neglect, with rates of 163/1,000 for physical neglect and 184/1,000 for emotional neglect (Stoltenborgh et al., 2013). Among the different areas affected by neglect, supervision has been identified as particularly frequent and relevant (Vanderminden et al., 2019). Despite its high prevalence rates and negative effects, neglect has been and continues to be the least studied and probably the most tolerated type of child maltreatment (Moody et al., 2018; Porchia-Usher, 2015; Stoltenborgh et al., 2013).

In Spain, data about prevalence of child neglect are scarce. The Unified Record of Child Maltreatment (RUMI) -that collects data from Child Protection Services of Spanish Autonomous Communities on the number and characteristics of child maltreatment referrals- found that in 2017, 52% of the referrals (n = 10,771) were due to neglect (Ministerio de Sanidad, Consumo y Bienestar Social, 2018). Findings of the largest study conducted in Spain with a sample of approximately 800 school professionals, showed that neglect represented 37.1% of children under 7 years of age who were considered by these professionals as victims of maltreatment (Ministerio de Sanidad, Política Social e Igualdad, 2011).

Neglect -particularly lack of supervision- can have fatal consequences on the child (Brandon, Bailey, Belderson, & Larsson, 2014; Welch & Bonner, 2013). Some studies have found that it causes or contributes to 30-75% of all child maltreatment-related deaths (Berkowitz, 2001; Child Welfare Information Gateway, 2018). Although in most cases the initial impact of neglect may not be obvious, research has found that its cumulative, and medium and long-term effects can be as or even more harmful than physical or sexual abuse. Negative outcomes associated with neglect include disruptions in brain development, attachment disorders (insecure or disorganized attachment patterns), health and physical problems (e.g., failure to thrive, impairment of the immune system), intellectual and cognitive problems (e.g., learning deficits, poor school performance, impaired language development), emotional and psychological problems (e.g., low self-esteem), and social and behavioral problems (e.g., interpersonal difficulties, social withdrawal, poor impulse control). In adolescence and adulthood, child neglect has been associated with criminal and antisocial behaviour, substance abuse and domestic violence (Child Welfare Information Gateway, 2018; Cicchetti & Toth, 1995; Gilbert et al., 2009; National Scientific Council on the Developing Child, 2012).

Scientific evidence has associated the risk of negative lifelong effects from neglect with the child´s age, and with the severity, duration, and timing of neglect. As neglect begins at younger ages and is more severe and chronic, its sequelae are more profound, pervasive, and difficult to recover. As scientific evidence clearly indicates, late interventions aimed at repairing the consequences of child maltreatment are less effective and more costly than preventive interventions, placing preventive and early intervention -particularly in the prenatal period and the first years of life- as the most efficient alternative (Child Welfare Information Gateway, 2019; National Scientific Council on the Developing Child, 2010, 2012; Zimmerman & Mercy, 2010).

SafeCare (www.safecare.publichealth.gsu.edu) is a structured home-visiting preventive and early intervention programme designed in the 1980s for parents who are at-risk or have been reported for child neglect and physical abuse with children 0-5 years (Guastaferro, Lutzker, Graham, Shanley, & Whitaker, 2012; Lutzker & Bigelow, 2002; Lutzker, Van Hasselt, Bigelow, Greene, & Kessler, 1998). SafeCare training to parents includes three module areas: parent-child interaction, health care, and home safety. The modules typically involve a baseline assessment and observation of parental knowledge and skills, followed by four parent training sessions, and conclude with a follow-up assessment to monitor change. Providers use a four-step approach during the parent training sessions to address target behaviors: (1) describe and explain the rationale for each behavior, (2) model each behavior, (3) ask the parent to practice the behavior, and (4) provide positive and constructive feedback. This approach is designed to promote generalization of skills across time, behaviors, and settings. The parent-child interaction module helps parents to provide their children with stimulating activities, to increase positive interactions, and to prevent child behavioural problems. The health care module trains parents to use child health materials, prevent health problems, and recognize and respond to symptoms of illness and injury. The home safety module involves the identification and elimination of dangers in the home for the safety and health of the child. SafeCare typically provides 18 to 24 weeks training, with weekly home visits of 60–90 minutes carried out by trained and certified providers.

SafeCare has been implemented in different countries (e.g., United States, Canada, Australia, United Kingdom, Japan, Israel). Outcome evaluations have shown significant positive effects of the programme on parental skills as involvement in organized activities, positive behaviours towards children, and use of appropriate techniques for managing child behaviour; recognition of health problems and provision of medical treatment to the child; and improvement of home safety (Bigelow & Lutzker, 2000; Churchill, 2015; Gershater-Molko, Lutzker, & Wesch, 2003). SafeCare has also shown efficacy at improving parenting skills in high-risk families, and at decreasing recidivism in neglectful families in follow-up evaluations of up to six years (Chaffin, Hecht, Bard, Silovsky, & Beasley, 2012; Silovsky et al., 2011). Recently, SafeCare Augmented, a reinforced version that includes motivational interviewing and domestic violence training, has been developed. According to the California Evidence-Based Clearinghouse for Child Welfare (www.cebc4cw.org), SafeCare is a programme of great relevance to the field of child protection (maximum rating) and is supported by research evidence (second level of five) for the prevention of child neglect. The Washington State Institute for Public Policy (www.wsipp.wa.gov) also classifies SafeCare as evidence-based.

In 2013, the Child Protection Services of Gipuzkoa and San Sebastián and the University of the Basque Country UPV/EHU signed an agreement for the pilot implementation of two evidence-based early intervention programmes, one of which was SafeCare (De Paúl, Arruabarrena, & Indias, 2015). This paper presents the process and results of this project.

Method

Participants

Between 2014 and 2017, 89 parents matching the following inclusion criteria were referred to the SafeCare programme: (1) presence or high-risk for physical or emotional neglect towards a child under 5 years of age; (2) the child was living at home with at least one parent, (3) the goal of Child Protection Services was family preservation; and (4) parents agreed to participate. Cases of sexual abuse or severe incidents of maltreatment towards other children in the family, or parents with severe problems of substance abuse, mental health problems or cognitive limitations that prevent them from benefiting from a parenting skills intervention were excluded. Table 1 presents the sociodemographic characteristics of the referred families. As Figure 1 shows, 71 parents initiated the programme. Of those, 46 finished it.

Table 1
Sociodemographic characteristics of families referred to the SafeCare programme ($N = 89$)

	N (%)	
Child gender		
Males	53 (60.2%)	
Females	35 (39.8%)	
Child age		
Less than 1 year	19 (21.6%)	
Between 1 and 3 years	30 (34.1%)	
Between 3 and 5 years	39 (44.3%)	
Average age in months [*M* (*SD*)]	28.5 (16.0)	
	Mothers n (%)	**Fathers n (%)**
Age		
Less than 20 years	9 (10.2%)	3 (6.5%)
Between 21 and 25 years	18 (20.4%)	11 (23.9%)
Between 26 and 30 years	24 (27.3%)	7 (15.2%)
Between 31 and 35 years	15 (17.1%)	6 (13.0%)
More than 35 years	22 (25.0%)	19 (41.3%)
Average age in years [*M* (*SD*)]	30.2 (7.7)	32.9 (9.8)
Origin		
Spanish	31 (35.2%)	17 (29.8%)
Inmigrant	57 (64.8%)	40 (70.2%)
Academic level		
No studies	8 (9.1%)	4 (9.7%)
Primary education	49 (55.7%)	21 (51.2%)
Profesional training/ Secondary education	24 (27.3%)	11 (26.8%)
University	7 (7.9%)	5 (12.3%)
Work situation		
Stable employment	11 (12.8%)	11 (23.9%)
Tempory employment	10 (11.6%)	6 (13.0%)
Sporadic work	8 (9.3%)	2 (4.4%)
Unemployed/working at home	57 (66.3%)	27 (58.7%)
Family income		
With problems	64 (72.7%)	
Without problems	24 (27.3%)	
Type of family		
Two biological parents	39 (42.9%)	
One-parent family	4 (4.4%)	
Divorced	46 (50.6%)	
Other	2 (2.2%)	

Instruments

Three types of instruments were used to measure SafeCare programme outcomes.

Home visitors' evaluations. The instruments provided by SafeCare were used to measure goals achievement in the programme modules. For the parent–child interaction module, the Activities of Daily Living (ADL) checklist was used, which is an inventory of 14 items on the activities that parents carry out with their children that are observed and rated by the home visitor on a scale of 1-4. For the health care module, a form was used to rate the knowledge of the parents in three scenarios selected among 40 hypothetical situations related to the health care of their children. For the home safety module, the Home Risk Prevention Inventory (HAPI) was used, designed to assess hazards that could affect children at home (29 hazardous items classified in 10 categories) (Tertinger, Greene, & Lutzker, 1984). Finally, home visitors made a global assessment of the skills acquired by the parents in each module. For the parent-child interaction and home safety modules, scores range from 3 to 9. For the health module, from 1 to 3.

Standardized instruments

Brief Child Abuse Potential Inventory (B-CAP).The B-CAP is a self-report instrument developed as a short version (34 items) of the CAP Inventory (De Paúl, Arruabarrena, & Milner, 1991; Ondersma, Chaffin, Mullins, & LeBreton, 2005) to measure the risk of a parent to physically abusing their children.

Parenting Stress Index/Short Form (PSI/SF) (Abidin, 1995). The PSI/SF is a 36-item self- report instrument that measures the level of stress associated with the parental role. It includes three scales: parental distress, dysfunctional parent-child interaction, and difficult child.

Beck Depression Inventory-2 (BDI-2) (Beck, Steer, & Brown, 1996). The BDI-2 is a 21-item self-report multiple-choice instrument to measure depressive symptomatology.

Eyberg Child Behavior Inventory (ECBI) (Eyberg & Pincus, 1999). The ECBI is a 36-item questionnaire to measure parental perception about child's behaviour at home.

Parental satisfaction. At the end of the programme parents completed a questionnaire to measure satisfaction with SafeCare

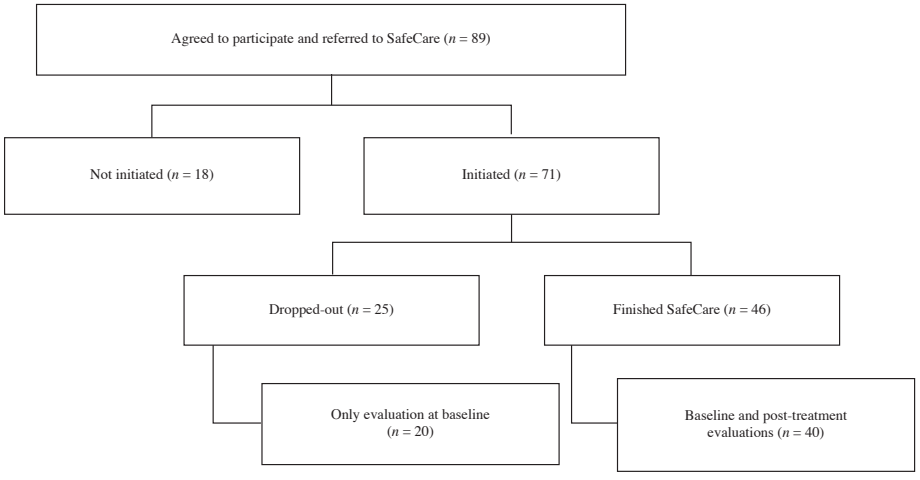

Figure 1. Number of referrals to the SafeCare programme, and parents who initiated, dropped-out and finished

activities and perception about its usefulness. The questionnaire was provided by the programme, and included 35 items rated on a Likert scale of 1-5 (1, 'very dissatisfied'; 5, 'very satisfied').

Procedure

The first activity carried out for the pilot implementation of SafeCare in Spain focused on the adaptation of documents to be used by professionals and families. Written documents, previously translated into Spanish by the National SafeCare Training and Research Center (NSTRC), were reviewed by members of the research team of the University of the Basque Country to ensure that terminology and content were appropriate for the Spanish context. Language and surface content adaptations were carried out with the advice of pediatricians of the Basque Country Public Health System, and the supervision of the NSTRC.

The second activity carried out for the SafeCare pilot implementation was Home Visitors and Coaches selection and training.

Requirements to be trained as home visitor of SafeCare included academic degree in human services (e.g., social work, social education, psychology), and previous experience working with families in the Child Protection System. Also, home visitors should maintain a positive attitude and openness to learning and implementing a new and structured intervention protocol, and should be well-respected in their agencies. Based on these criteria, six women (four social workers, one psychologist, and one social educator) were selected for training.

These people attended a five-day workshop provided by a certified Hispanic trainer from NSTRC, to be trained in SafeCare modules, communication with families, and structured problem solving. Then, trainees started the implementation of SafeCare with 18 families previously referred to the programme. During the nine months training period, home visits were audio-recorded and shared with the trainer. Home visitors received individual weekly phone calls and monthly online group sessions for supervision and consultation. Four months after the first workshop, home visitors attended a second workshop of three days, and received in vivo supervision from the trainer in the family homes. Once trainees demonstrate mastery of SafeCare skills in the field, they were granted certification.

As a requirement for SafeCare implementation, two home visitors were selected to be trained as coaches in an additional two-day workshop. Coach training prepares an individual to provide onsite coaching for home visitors. To become certified, coach trainees must demonstrate coaching skills and mastery in fidelity monitoring. At the end of the training process, six home visitors received their certification, and two were also certified as coaches.

Once the SafeCare programme was implemented, home visitors and participating parents were asked to complete baseline and post-treatment instruments. The research was approved by the Ethics Committee of the University of the Basque Country (Spain).

Data analysis

Data were analyzed using the SPSS 22 statistical package, with descriptive statistics and *t*-test analyses. Cohen's (1988) effect size was estimated for statistically significant differences.

Results

As Figure 1 shows, 20.2% of the parents who signed the participation agreement in SafeCare did not initiate the programme, and 35.2% dropped out before completion. No significant differences were found in the sociodemographic characteristics of the families who did not initiate, dropped out, and finished the programme (see Table 2), nor between families who dropped out and finished SafeCare in the standardized measures at baseline (see Table 3).

Parents who finished SafeCare received, on average, more home visits than the required minimum (18 sessions) but without reaching the maximum of 24 sessions. The average length of intervention was 7.5 months (Table 4). With the 25 parents who dropped out, an average of 12.7 sessions were arranged and received 184 home visits (7.4 sessions per family) during an average time of longer than 4 months.

Home visitors assessments. Table 5 shows the mean scores assigned by home visitors to the 40 parents evaluated before and after the intervention. Statistically significant positive changes were observed ($p < .001$) for the three modules: parent-child interaction, child health, and home safety.

S*tandardized measures*. Table 6 shows the scores obtained by the 40 parents who completed the standardized measures at baseline and after the intervention. *T*-test analyses showed

Table 2
Characteristics of families referred to the SafeCare programme who 'did not initiate', 'dropped out' and 'finished' the intervention

	Not initiated n (%)	Dropped out n (%)	Finished n (%)
Physical neglect			
No present or at risk	14 (18.4%)	21 (27.6%)	41 (53.9%)
Low or moderate severity	4 (30.8%)	4 (30.8%)	5 (38.5%)
Emotional neglect			
No present or at risk	7 (13.2%)	16 (30.2%)	30 (56.6%)
Low or moderate severity	11 (30.5%)	9 (25.0%)	16 (44.4%)
Emotional abuse			
No present or at risk	15 (20.3%)	22 (29.7%)	37 (50.0%)
Low or moderate severity	3 (21.4%)	2 (14.3%)	9 (64.3%)
Child gender			
Male	10 (18.9%)	19 (35.8%)	24 (45.3%)
Female	7 (20.0%)	6 (17.1%)	22 (62.9%)
Child's age			
Less than 1 year	6 (31.6%)	6 (31.6%)	7 (36.8%)
Between 1 and 3 years	7 (23.3%)	4 (13.3%)	19 (63.3%)
Between 3 and 5 years	4 (10.3%)	15 (38.5%)	20 (51.3%)
M (SD) months	20.8 (17.2)	33.4 (17.7)	28.8 (13.7)
Origin			
Spanish	11 (19.3%)	16 (28.1%)	30 (52.6%)
Immigrant	6 (19.4%)	9 (29.0%)	16 (51.6%)
Family income			
With problems	15 (23.4%)	17 (26.6%)	32 (50.0%)
Without problems	2 (8.3%)	8 (33.3%)	14 (58.3%)
Type of family			
Two biological parents	7 (18.4%)	12 (31.6%)	19 (50.0%)
One-parent family	6 (16.2%)	8 (21.6%)	23 (62.2%)
Divorced	3 (30.0%)	4 (40.0%)	3 (30.0%)
Other	1 (33.3%)	1 (33.3%)	1 (33.3%)

Table 3
Baseline scores of families who finished and who dropped out of the SafeCare programme

	Finished M (SD)	Dropped out M (SD)	t-test
Child abuse potential (B-CAP)	7.89 (5.1)	10.54 (5.6)	t (64) = –1.94 (p = .06)
Parental stress (PSI)			
Parental distress	28.0 (8.9)	32.41 (9.7)	t (64) = –1.83 (p = .07)
Dysfunctional parent–child interaction	21.84 (7.5)	23.27 (7.9) 30.95 (9.6)	t (64) = –.72 (p = .48) t (64) = –.67 (p = .50)
Difficult child	29.39 (8.6)	86.64 (20.8)	t (64) = –1.38 (p = .17)
Total PSI	79.25 (20.4)	12.10 (9.7)	t (62) = –1.77 (p = .08)
Depressive symptomatology (BDI)	7.98 (8.1)		
Behavioural problems (ECBI)			
ECBI intensity	106.56 (31.0)	112.23 (31.5)	t (54) = –.63 (p = .53)
ECBI problems to manage	11.08 (8.2)	12.64 (8.8)	t (48) = –.59 (p = .56)

significant decreases (p < .05), although of small size (Cohen's d = 0.20–0.49), in child abuse potential (B-CAP) and stress associated with the parental role (PSI), including the two dimensions of parental distress and perception of difficult child. A statistically improvement of medium size (Cohen's d = 0.50–0.79) was found in the perception of the parents about the intensity of child behavioural problems and their ability to cope with them. A decrease in the mean scores for depressive symptomatology between baseline and post-treatment was found, although not reaching statistical significance.

Parental satisfaction. The assessment of parents on the usefulness of the skills acquired during SafeCare intervention was very high for the three modules (range 1-5): parent–child interaction (M = 4.38, SD = .90), health care (M = 4.32, SD = .43) and home safety (M = 4.44, SD = .64). The total satisfaction score was also high (M = 153.3, SD = 16.7; for a maximum score of 175).

Discussion

The first relevant lesson learned from the present study was the feasibility of implementing the SafeCare programme in Child Protection Services in Spain, and for the target population for which it was designed. A group of home visitors and coaches were trained, obtained certification, benefited from supervision, and were able to correctly implement the programme with fidelity. These professionals adapted perfectly to the requirements of an evidence-based programme such as SafeCare, and were able to respond to a highly monitored and supervised practice. A significant number of families actively participated in structured home visits, and all the parents who finished the programme rated very positively its usefulness and the skills acquired.

Of concern was the finding of the high number of parents who did not initiate or dropped out the programme, although drop-out rates found in the present study (35.7%) were similar to those

Table 4
Number of home visits (programmed and conducted) and length of the intervention with families who finished and who dropped out of the programme

	Finished M (SD)	Dropped out M (SD)
Number of programmed home visits	23.8 (4.3)	12.7 (7.7)
Number of conducted home visits	19.7 (2.7)	7.4 (5.1)
Total length of the intervention (months)	7.5 (1.9)	4.3 (2.7)

Table 5
Baseline and post-treatment scores of the Home visitors in the SafeCare Parent–child interaction, Health care, and Home safety modules

	Baseline M (SD)	Post-treatment M (SD)	t-test
Parent–child interaction			
Activities of Daily Living (ADL)	41.22 (7.9)	47.89 (4.9)	t (44) = -6.7 (p < .001)
Number of behaviours acquired	3.87 (4.1)	17.06 (7.0)	t (48) = -12.6 (p < .001)
Global score (range 3-9)	3.14 (0.5)	6.77 (1.5)	t (48) = -15.6 (p < .001)
Health care			
Evaluation Form	211.45 (54.3)	278.72 (30.7)	t (46) = -8.8 (p < .001)
Global score (range 1-3)	1.55 (0.7)	2.57 (0.5)	t (46) = -8.3 (p < .001)
Home safety			
HAPI	93.7 (64.7)	24.5 (26.5)	t (41) = -8.0 (p < .001)
Global score (range 3-9)	3.28 (0.7)	6.83 (1.8)	t (41) = -12.9 (p < .001)

Table 6
Baseline and post-treatment scores for standardized instruments completed by parents

	Baseline M (SD)	Post-treatment M (SD)	t-test	d*
Child abuse potential (B-CAP)	8.32 (5.1)	6.77 (5.20)	t (39) = 2.14 (p = .039)	.30
Parental stress (PSI)				
Parental distress	28.45 (9.1)	26.32 (8.25)	t (39) = 2.04 (p = .048)	.25
Dysfunctional parent–child interaction	21.65 (7.5)	19.95 (6.39)	t (39) = 1.84 (p = .073)	
Difficult child	29.25 (8.7)	26.30 (7.31)	t (39) = 2.60 (p = .013)	.37
Total PSI	79.35 (21.1)	72.57 (18.23)	t (39) = 3.10 (p = .004)	.34
Depressive symptomatology (BDI)	8.40 (8.4)	6.30 (7.14)	t (39) = 1.92 (p = .057)	
Behavioural problems (ECBI)				
ECBI intensity	104.69 (31.69)	88.91 (23.15)	t (39) = 3.16 (p = .003)	.57
ECBI problem to manage	12.14 (8.53)	7.44 (7.16)	t (39) = 2.87 (p = .008)	.60

* Cohen effect size d: 0.20–0.49, small; 0.50–0.79, medium; ≥ 0.80, high

reported in previous applications of SafeCare in USA (45.5%; Gershater-Molko, Lutzker, & Wesch, 2003) and more recently in United Kingdom (27%; Damashek, Doughty, Ware, & Silovsky, 2011). These rates could be related to the intrinsic difficulties of adherence to preventive programmes (Damashek et al., 2011) or to the limited problem awareness and motivation for change of many high-risk and neglectful parents, supporting the incorporation of strategies such as the Motivational Interview (Miller & Rollnick, 2013; Miller, Yahne, Moyers, Martinez, & Pirritano, 2004), particularly in Child Protection Services (Forrester et al., 2018). In fact, the recently developed SafeCare Augmented version includes training in motivational interviewing (Silovsky et al., 2011).

In the present study, the length of the SafeCare programme was adjusted to what was expected (6 months) only for a small number of parents. For 31% of them, it was somewhat higher than expected (7/8 months), and for 27% it was much higher (8/12 months). These findings were similar with those reported in a recent implementation of SafeCare in United Kingdom, with an average length of treatment close to 9 months (Damashek et al., 2011).

Positive changes informed by home visitors in the families who finished SafeCare in parent-child interaction patterns, health care, and home safety suggested that the programme can be useful to reduce child neglect or to prevent it in high-risk families. Also, positive changes in parental self-report measures were similar to those found in studies carried out in other countries (Chaffin et al., 2012; Churchill, 2015; Damashek et al., 2011; Gershater-Molko et al., 2003), and suggested that SafeCare can improve relevant aspects of the personal well-being of parents, reduce parental stress related to child care, and improve parental perception of the child.

The main limitation of the present study was the absence of a control group to elucidate which and how many of the changes observed in the participating families were due to the SafeCare intervention. The small sample size made it impossible. The number of families referred to the SafeCare programme was much lower than expected, given the prevalence of child neglect. Future studies should explore the capacity of the Spanish child protection system to detect and to provide support to high-risk and neglectful families at early stages.

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